**Student Name**_____ **Student ID** _____

# CREDENTIAL Packet For Phlebotomy Students

# Confidential Student Record

Germanna Community College
Nursing & Health Technologies
2130 Germanna Highway
Locust Grove, VA 22508

**List of REQUIRED Credentials**

# Germanna Community College Healthcare Program

| **Documentation of credential** | **Expiration date UPDATED EACH SEMESTER as needed** |
|---|---|
| CPR for **American Heart Association: Healthcare Professional-Basic Life Support** required<br>(must include AED and 2 rescuer CPR)<br>● online classes must have signed demonstration included. | |
| TB documentation: PPD, TST, IGRA<br>Annual (within the last 12 months) or<br>Negative chest x-ray (within 5 years) | |
| Professional Student Nurse<br>Insurance current https://www.nso.com/ | |
| Personal<br>Health Insurance Documentation | |
| Hepatitis B Vaccine Series started or complete<br>If not complete additional vaccine documentation to be submitted to CastleBranch as completed.<br><br>Or waiver | |
| Tetanus Vaccine | |
| Rubella Documentation<br>Titer or vaccine | |
| Rubeola Documentation<br>Titer or vaccine | |
| Mumps Documentation<br>Titer or Vaccine | |
| Varicella Zoster Documentation<br>Titer or vaccine | |
| Drug Screen 10 panel random substance screen<br>(within the last 6 months) | |
| Seasonal Flu Vaccine or Waiver | |
| High School Diploma on file with Admissions & Records | |

***Please scan documents to:***

Package Code, **ER41 – Phlebotomy Document manager**

www.castlebranch.com

*For questions regarding this packet, please email*

kmittura@germanna.edu, asheaffer@germanna.edu

**Updated 11/2020 km**

# ****ATTENTION Healthcare APPLICANTS****

*A criminal history record must be submitted with the healthcare program application. Admission to the program will be contingent upon the results of the background check. Please see the information below for acquiring a background check.*

**Misrepresentation on the application will result in dismissal from the Nursing Program.**

# CastleBranch.com
## Instructions
## Germanna Community College

## Background Check Required

The facility where you have nursing clinicals require that each student purchase a background check through CastleBranch.com.

## About Castle Branch

**Castle Branch** is a secure platform that allows you to order your background check, drug test and medical document manager online. Once you have placed your order, you may use your login to access additional features of **Castle Branch** including document storage, portfolio builders and reference tools. **Castle Branch** also allows you to upload any additional documents required by your school.

To submit your request to CastleBranch.com, please follow below instructions.

## Instructions

1. Go to www.CastleBranch.com (follow instructions on website)
2. Package Code **ER55bg – Background + Employment Verifications X 3, $87.75-Use to apply to the Nursing program.**
    a. Once your background check order is submitted, you will receive a **password** to view the results of your background check (*available in approximately 48-72 hours*).
3. Package Code**, ER55dt - Drug Test Only, $37.00** (once accepted into the program, part of Credential Packet)
    a. **Drug Test (LabCorp)** – within 24-48 hours after you place your order, the electronic chain of custody form (echain) will be placed directly into your Castle Branch account. This echain will explain where you need to go to complete your drug test.
4. Package Code, - **Background Check + Drug Test + Employment Verifications X 3, $124.75**
    a. Applicable where applying to a program where background check & drug test are required with application.
5. Package Code, **ER55ver-Employment Verifications X3, $21.00**
6. Package Code, **ER41phl – Background for phlebotomy**
7. Package Code, **ERdt-Drug Screening for all programs**
8. Package Code, **ER55re – Recheck Background Check, $32.00**
9. Package Code **GD60 – Background for CMA**
10. **Package Code GE34 – Background for Medical Administrative Specialist**
11. Payment Information - At the end of the online order process, you will be prompted to enter your Visa or Mastercard information. Money orders are also accepted but will result in a $10 fee and an additional turn-around-time.

The above package codes are required for Germanna Community College Healthcare students.

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# 10 Panel Drug Screen

Amphetamines

Barbiturates

Benzodiazepines

Cocaine

Methaqualone

Marijuana

Methadone

Opiates

Phencyclidine

Propoxyphene

**Drug Test (LabCorp)** – within 24-48 hours after you place your order, the electronic chain of custody form (e-chain) will be placed directly into your Castle Branch account. This e-chain will explain where you need to go to complete your drug test.

**STATEMENT OF UNDERSTANDING**

I certify the areas marked on this check off sheet are complete and all forms and documentation are provided to www.CastleBranch.com. I understand that Germanna Community College Department of Nursing and Health Technologies is required by policy and contracts with the various facilities to have this information on hand before I am allowed to attend assigned clinical.

I further understand that failure to provide this information may result in my receiving an Administrative Withdrawal from the program.

| | |
|---|---|
| _____ | _____ |
| Print Name | Student ID |
| _____ | |
| Signature of Student | Date |

# HIPAA
# Privacy Program
# Statement of Understanding

## First: Review HIPAA PowerPoint tutorial

## Second: Complete agreement below

I _____have been trained and informed about the practice related to confidentiality as a result of the Health Insurance Portability and Accountability Act (HIPAA). I understand that I must ensure the privacy of all clients/patients or participant's information obtained and held by all clinical settings.

Signature: _____

Date:_____

**Germanna Community College**

**TYPICAL PHYSICAL DEMANDS:** Requires full range of motion including handling and lifting patients, manual and finger dexterity and eye-hand coordination. Requires standing and walking for extensive periods of time for possible periods of time: 8-12 hrs. Occasionally lifts, carries and pushes items weighing up to 50 pounds. Requires corrected vision and hearing to normal range. Requires working under stressful conditions or working irregular hours. Requires exposure to communicable diseases or body fluids.

I have read the above statement:

_____ Date: _____

**Immunization guidelines**

1. **Hepatitis B Vaccine (3) and titer**_____/_____/_____/_____
   #1 date (Initial) (after #1) | #2 date (1 Month) (after #2) | #3 date (4-5 Months) (after #3) | Titer date (OPTIONAL)
   **Documentation of results required**

   **OR** Waiver of Responsibility ___/___/____ **( Waiver not applicable if vaccines have been started)**
   **Date**

2. **Tetanus Vaccine** ___/_____/__ (Within 10 Years)
   **Date**
   **Documentation of immunization required**

3. **Required Immunizations**
   **2** MMR Vaccines (In childhood) ___/____/___ - ____/___/___
   **Date** **Date**
   **Documentation of immunization required**

   **OR** 1 Current MMR Vaccine ((Within last 12 months) ___/____/____
   **Date**
   **Documentation of immunization required**

   **OR** Rubella Titer (German Measles) ___/___/____ / _____
   **Date** **Reactive**
   AND
   Rubeolla Titer (Red Measles) ___/___/____ - _____
   AND
   Mumps Titer ___/___/____/ _____

4. **Immunization Requirements**

   Varicella Vaccine __/___/_____
   Varicella Vaccine #2 at 28 days __/___/_____
   **Documentation of immunization required Date**

   **OR** Varicella Zoster IgG Antibody Titer __/___/_____ - _____
   **Documentation of titer required** **Date** **Reactive**

5. **PPD, TST or IGPA documentation Annual or Negative Chest X-ray (within 5 years)** ___/___/_____ - _____
   **Date** **Reactive**

6. **Flu immunization** ___/___/___
   **Date**

   **OR** Waiver of Responsibility ___/___/____ **( Required to wear Face Mask)**
   **Date**

**(Optional)**

**HEPATITIS B VACCINE DECLINATION FORM**

**(This form invalid if vaccine series has been started)**

I understand that during my educational experience in the Nursing & Health Technologies Program/Workforce Health care programs at Germanna Community College I may have exposure to blood or other potentially infectious materials and may be at risk of acquiring hepatitis B (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B. which is a serious disease.

I acknowledge that I have read this information by signing below.

_____/_____/_____
Printed Name of Student Date

_____/_____/_____
Signature of Student Date

**(Optional)**

**Influenza VACCINE DECLINATION FORM**

**Students will be required to sign this form each semester.**
**Students will be required to wear a facemask in the clinical setting.**

I understand that during my educational experience in the Nursing & Health Technologies Program/Workforce Health care Programs at Germanna Community College, I may have exposure to the flu and patients that are immunosuppressed, However, I decline the Influenza vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring the flu and transmitting it to patients in clinical settings.

I may be required to wear a facemask in the clinical setting. I may not be permitted to enter the clinical setting without the vaccination.

I acknowledge that I have read this information by signing below.

_____/_____/_____
Printed Name of Student Date

_____/_____/_____
Signature of Student Date

GERMANNA COMMUNITY COLLEGE

**All Student Records are maintained securely and privacy is protected. Clinical Facilities may request student clinical credentials.**

**Consent for Release of Confidential Medical Information to Germanna Community College**

I, _____ DOB _____/____/____ Student ID_____

Address _____ City _____

State _____ Zip Code _____ Phone (_____) _____

Authorize Germanna Community College to release the information specified below to a clinical agency upon request, in accordance with the laws of Commonwealth of Virginia, to the following party:

**Release Information to Person/Organization as noted below:**

| | |
|---|---|
| Name: | Dr. Patricia Lisk, Dean of Nursing and Health Technology |
| Organization: | Germanna Community College |
| Street Address: | 2130 Germanna Highway |
| City, State, Zip: | Locust Grove, VA 22508-2102 |
| Phone: | (540) 423-9820 |

**Information to potentially be released**

Urine Drug Screen
PPD Test Result
Vaccine Records/Titer Results
Radiology
Physical/Dental Information
Criminal Background Record

The purpose for the disclosure of the above information is:

**Credential requirements for Nursing & Health Technology Program at Germanna Community College**

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release the above mentioned facility from, and covenant not to sue them for any claim I have or may in the future for the release of this information. This information may be disclosed from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:

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Student Signature: _____ _____/_____/_____

# Confidentiality Form

I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.
Associate/Physician/Consultant/Vendor/Office Staff Signature Facility Name Date
Associate/Consultant/Vendor/Office Staff Printed Name Department

## Confidentiality and Security Agreement

I understand that Mary Washington Healthcare and its related entities in which or for whom I work, volunteer or provide services, or with whom the entity for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the"System"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' protected health information. Additionally, the System must assure the confidentiality of its human resources, fiscal,research, internal reporting, strategic planning information, or any other information that contains Social Security numbers, healthinsurance claim numbers, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").
In the course of my employment / assignment at the System, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with this Confidentiality and Security Agreement. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will only access information systems to review patient records or System information when I have a business need to know that information, as well as any necessary consent. By accessing a patient's record or System information, I am affirmatively representing to the System at the time of each access that I have the requisite business need to know that information and the System may rely on that representation in granting such access to me.

2. I will not disclose or discuss Confidential Information with others, including friends or family, who do not have a need to know it.

3. I will not in any way copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.

4. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information in a public area even if the patient's name is not used.

5. I will not access my own medical information or the medical information of my family members for personal reasons.

6. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

7. I will practice good workstation security measures such as securing a terminal when I leave it unattended and positioning screens away from public view.

8. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.

9. I will:

a. Use only my officially assigned User-ID and password (and/ortoken (e.g., SecurID© card)).
b. Use only approved licensed software.
c. Use a device with virus protection software.

10. I will never:

a. Disclose passwords, PINs, or access codes.
b. Use a terminal on which another individual has signed-on.
c. Use tools or techniques to break/exploit security measures.

11. I will notify Information Services if my password has been seen, disclosed, or otherwise compromised (540.741.1122).

12. If applicable, I will notify Information Services immediately if my SecurID token is lost or stolen (540.741.2420).

13. I will report activity that violates this agreement, System privacy and security policies, or any other incident that could have any adverse impact on Confidential Information to the Privacy Officer via the Mary Washington Healthcare Values Line
(1.800.442.8762).

14. If applicable, I will ensure that only appropriate personnel in my office will access the System's Confidential Information and accept full responsibility for the actions of my employees who may access System's Confidential Information.

15. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the System.

16. Upon termination of my relationship with the System, I will immediately return any documents or media containing Confidential Information to the System.

17. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with the System.

18. I understand that I should have no expectation of privacy when using System's information systems. The System may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.

19. I understand that access to the Internet is provided to facilitate the performance of assigned duties. I also understand that I am authorized to access only those sites that pertain to business and am not authorized to access sites for personal use. I understand that Internet utilization will be monitored and unauthorized or inappropriate use may result in disciplinary action, up to and including termination.

20. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the System, in accordance with the System's policies.

21. I understand that the use and disclosure of Confidential Information is regulated by law, and that inappropriate use or disclosure may result in criminal penalties and/or civil liability.

_____

_____

Signature of student Date

_____

Student ID